AN INTRODUCTION

TO

MEDICAID ELIGIBILITY

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PREFACE

The purpose of this guide is to provide a general introduction to Medicaid eligibility. Because it is a complex and constantly evolving policy area, no attempt has been made to discuss all aspects of Medicaid eligibility. Rather, this guide is intended to provide a basic framework for understanding the major coverage options under Medicaid - what they are, what they are designed to do, why they are important, and how eligibility under these provisions is generally determined.

The discussion is divided into two parts. Part I provides a general overview of Medicaid eligibility with special emphasis on mandatory coverage groups. Part II provides a further discussion of major optional coverage groups and certain other requirements, which are deserving of separate consideration in view of their special importance or complexity.

The emphasis throughout this guide is on general principles and the rationale behind major requirements and options for coverage. Eligibility, however, is by its very nature a highly technical area. General rules have to be interpreted to cover a bewildering variety of special situations. The complexity of Medicaid eligibility is further heightened by the fact that a knowledge of the policies and procedures of the cash assistance program is also essential.

This guide is a first step. For a more comprehensive treatment of Medicaid eligibility policy, the reader is referred to Medical Assistance Manual, Part IV.

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PART I

Medicaid is one of the most important components of the current welfare system, and its eligibility provisions are among the most complex, if not the most complex, of all assistance programs. In order to understand the complicated provisions for coverage under Medicaid, it is essential to review the relatively recent history of the cash assistance programs, in relation to which Medicaid eligibility has traditionally been established. Much of the current complexity of Medicaid eligibility policy is directly traceable to recent changes in the provision of cash assistance. The key development was the creation of the Supplemental Security Income (SSI) program, which replaced the earlier programs of financial assistance for the aged, blind, and disabled. The SSI program was enacted under Public Law 92-603 in October, 1972, and the program was implemented by the Social Security Administration in January, 1974. The creation of SSI under the revised Title XVI of the Social Security Act had a major and visible impact on eligibility for cash assistance and an equally dramatic, though often poorly perceived impact on Medicaid eligibility. Several pieces of legislation were necessary subsequent to PL 92-603 to accommodate the coverage provisions under Medicaid to the changes brought about by SSI.

MEDICAID ELIGIBILITY PRIOR TO SSI

To understand the impact of SSI on Medicaid eligibility, it is important to describe briefly the earlier relationship of Medicaid to the cash assistance programs that SSI replaced.

The earlier cash assistance programs were established in 1935 and 1950 under the Social Security Act, which by the latter date recognized four major categories of needy individuals considered deserving of public

financial assistance. The categories were the aged, the blind, the disabled (the so-called adult categories), and families in which children were deprived of the support of at least one parent through death, incapacity, or continued absence from the home. The programs of Old Age Assistance (OAA), Aid to the Blind (AB), Aid to Families with Dependent Children (AFDC), which were enacted in 1935, and Aid to the Permanently and Totally Disabled (APTD), added in 1950, were funded jointly out of Federal and State revenues but administered by the States. Under these programs, States were free within broad Federal requirements to determine standards of need; the amount of cash assistance to be paid; the definitions of blindness, disability, and deprivation to be used; and other conditions of eligibility to be imposed, such as State residence and the value of property that could be held.

Eligibility for cash assistance under these programs was conceptually organized around three primary elements:

a. A person had to be categorically-related; that is blind, aged (65 or older), disabled, or a member of family unit deprived of the support of a parent.

b. A person had to be eligible on the basis of income.

c. A person had to be eligible on the basis of liquid and non-liquid resources at his disposal.

In short, a person had to be both categorically-related and financially eligible, or categorically needy.

It is important to note that certain options for coverage were permitted within the Federal regulations governing the cash assistance programs.

Coverage of certain groups were required; coverage of others was a matter of State option. For example, under Federal regulations governing AFDC States could extend cash assistance to a single woman on behalf of an unborn child as a family unit, but they were not required to do so.

Prior to Medicaid, limited medical assistance was provided through budgeting for medical needs in determining eligibility under the cash assistance programs. However, including amounts for medical needs in the cash payment did not guarantee that the amounts budgeted would be sufficient to cover the actual cost of medical care and did not prevent these amounts from being used by recipients to meet other, and often more pressing, immediate needs. As a result, recipients of cash assistance still had to rely to a large extent on the charity of individual practitioners and institutions when confronted with a medical emergency, and their access to adequate medical care under these circumstances could be extremely limited.

In 1965, Medicaid was established under Title XIX of the Social Security Act to overcome these problems in the provision of medical assistance through a more effective and efficient system of direct payments to providers of medical care on the recipient's behalf. Such an approach was designed to remove the financial barriers which often prevented cash assistance recipients from seeking adequate care and to increase their access to care by assuring providers of adequate and prompt payment for services. Like the cash assistance programs, Medicaid was established as a jointly funded, State administered program. Similarly, within broad Federal guidelines, coverage under Medicaid was made mandatory for certain groups and optional for others.

States, at a minimum, had to cover recipients of cash assistance under AFDC, OAA, AB, and APTD (and later children who would be eligible for AFDC except for age and school attendance requirements). States could also elect

to extend Medicaid to the other optional coverage groups recognized under the Federal regulations governing the cash assistance programs, whether or not these groups were actually included in the State's programs of cash assistance. Using the previous example, a State could elect not to cover unborn children under its AFDC program, but could elect to extend Medicaid coverage to financially eligible single women on behalf of unborn children. Such groups under Medicaid are commonly referred to as optional categorically needy coverage groups, or medical assistance only (MAO) coverage groups. Two of the more important of these optional categorically needy coverage groups are individuals in medical institutions (See Part II) and financially-eligible children under 21 whether or not they were categorically-related (i.e. qualify as dependent children), or reasonable classifications of such financially-eligible children.

Apart from the mandatory and optional categorically needy coverage groups, States could exercise another broad option under Medicaid to extend medical assistance to the medically needy. The medically needy were defined as categorically-related individuals (i.e. aged, blind, disabled, and dependent children) who were ineligible for cash assistance on the basis of income and financial resources but whose income and resources were considered insufficient to meet their medical needs. Generally, States electing to cover the medically needy were permitted to establish higher income standards, medically needy income levels, and higher limitations on resources against which eligibility for Medicaid could be determined. All groups covered under Medicaid as categorically needy, whether mandatory or optional, had to be included under a medically needy program. In addition, under the medically

needy program categorically-related individuals and families with income in excess of the medically needy income levels could establish eligibility by deducting incurred medical expenses from their income and cash resources until remaining income was less than the medically needy income level. This procedure is known as the medically needy spenddown and the amount of income in exesss of the medically needy income levels is commonly known as the individual's or family's spenddown liability. (See Part II)

Before discussing the implementation of SSI, a few general observations are in order with respect to Medicaid eligibility prior to implementation of SSI.

In all States, recipients of cash assistance were automatically entitled to Medicaid, and a separate application for Medicaid was not required. In States covering the categorically needy only, certain medical assistance only determinations were made, but for those cases the policies and procedures of the existing cash programs to which the individual was categorically related were used, and the determinations were made by staff trained in the policies of the cash programs. In States covering the medically needy as well, Medicaid eligibility was somewhat more complicated because of the special features of the medically needy program. By and large, however, Medicaid eligibility was relatively simple from the standpoint of both policy and administration by contrast to what was to follow as a result of SSI implementation.

IMPLEMENTATION OF SSI - IMPACT ON CASH ASSISTANCE

Because of the relationship of Medicaid to the earlier cash assistance programs, it is helpful first to examine the effect SSI had on the provision of cash assistance before considering the changes in Medicaid eligibility resulting from implementation of SSI.

As indicated earlier, the major impact of the new Title XVI was to replace the programs of Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled and to consolidate the provision of cash assistance to these categories under one program. SSI was established with a view toward several important goals, among the most important of which were:

a. to provide fiscal relief to States through the creation of a Federally-funded, Federally administered cash assistance program.

b. to establish uniform national standards and conditions of eligibility, and

c. to provide for a minimum standard benefit level for all eligible aged, blind, and disabled individuals.

The initial legislation establishing SSI anticipated some of the varying effects implementation would have on the receipt of cash assistance.

In States which had more liberal categorical conditions for eligibility or higher financial standards under OAA, AB, and APTD, implementation of SSI would have resulted in the loss of eligibility for many recipients of cash assistance in the transition to SSI. To prevent this situation from occurring, a number of provisions were contained in PL 92-603 and subsequent legislation to guarantee to the extent possible that recipients of cash assistance would not be adversely affected by SSI either through a loss of eligibility or by a reduction in the amount of cash benefits they had been receiving. It should be noted that a loss of eligibility for cash assistance could have occurred for two reasons in States with more liberal standards.

First, individuals could have lost eligibility for cash assistance on the basis of their categorical relationship, because of more restrictive definitions of the degree of disability or visual impairment used under SSI to establish eligibility. Secondly, individuals could have lost eligibility on the basis of lower income and resource levels used under SSI. To prevent the first situation from occurring, recipients of AB or APTD were deemed to meet the SSI criteria for disability or blindness in States with more liberal categorical definitions. (Note: The basic rule was that these individuals were deemed to meet SSI criteria if they have been receiving cash assistance under AB or APTD in December, 1973, that is, immediately prior to implementation of SSI, and if they had been determined eligible according to State criteria in effect at the time SSI was enacted under PL 92-603 in October, 1972. This rule was to prevent States from liberalizing their definitions of blindness and disability for the sole purpose of making individuals eligible for SSI. Additional limitations were placed on deeming of the disabled.) For recipients of OAA, no such deeming was necessary, since the categorical definition of the elderly did not change under SSI. In the second situation, to prevent otherwise eligible recipients from losing cash assistance or from having benefits reduced as a result of SSI on the basis of income, States with more liberal financial standards under OAA, AB, or APTD were required to pay the difference between the lower SSI benefit and the individual's previous cash benefit. This requirement is called mandatory supplementation. Although the mandatory supplement comes out of State revenues, it may at State option be administered by the Federal Government under agreements between the States and the

Social Security Administration. Both individuals who were deemed to meet SSI categorical criteria and/or those who qualified for mandatory State supplementary payments are commonly known as grandfathered groups. In summary, OAA, AB, and APTD recipients in States with more liberal criteria and/or higher benefit amounts for cash assistance did not immediately benefit through implementation of SSI but were not adversely affected. These States, by the same token, were not expected to experience a major increase in the cash assistance population.

In States which had more restrictive definitions for blindness and disability and more restrictive financial standards, the impact of SSI on recipients of cash assistance under the previous programs was positive, although there might still be some individuals in special circumstances for whom a mandatory supplement payment might have to be made. Generally, in these States, recipients of OAA, AB, and APTD were not threatened by a loss of eligibility through changed definitions of blindness or disability and benefited from the higher benefit levels under SSI. These States were, of course, expected to experience an increase in the number of recipients of cash assistance as a result of SSI.

Finally, it should be noted that States could have had more restrictive categorical definitions but higher financial standards under OAA, AB, APTD or vice versa. The impact of SSI in these States therefore was expected to have mixed results on the size of the cash assistance population.

As indicated earlier, the replacement of the previous, jointly funded cash programs was expected to result in considerable savings to all States in welfare expenditures, whether or not a State had to make mandatory

supplement payments. Even in States required to supplement the SSI benefit up to previous financial standards, a considerable portion of the total payment to cash assistance recipients now came only out of Federal funds. In view of these anticipated savings, States were also permitted and encouraged to return all or a portion of the savings to the recipient population through a program of optional State supplementation. Optional supplementation was encouraged through a provision under which States electing to supplement the basic SSI benefit could enter into an agreement for Federal administration of the payments. However, to qualify for Federal administration, the optional supplement program had to meet certain conditions; namely, eligibility had to be determined in accordance with SSI eligibility criteria except for the use of more liberal disregards and a higher income level. Any State could elect to establish an optional supplementary payment program with the result that in some States a recipient might receive the basic SSI benefit, a mandatory supplement payment, and an optional supplement payment.

There is a major feature of State programs of optional supplementation which should be noted. States electing to make optional supplementary payments were not required to make them to all the categories of aged, blind, and disabled recipients under SSI. States could, if they chose, but were also permitted to limit optional supplement payments to reasonable classifications of categorically-related individuals. As an example, a State could establish an optional supplement program for the aged only, the blind only, the disabled only, or combinations of the three, among the major classifications considered reasonable.

IMPACT OF SSI ON MEDICAID ELIGIBILITY

After implementation of SSI in 1974, the provision of cash assistance to the traditional adult welfare categories had been radically altered, although no change had occurred in the provision of cash assistance to families with dependent children under AFDC. In addition, the so-called adult categories now included children, since SSI provided benefits to financially eligible blind and disabled individuals under 18 in contrast to the earlier cash programs. The basic groups of individuals eligible for cash assistance now included:

a. AFDC recipients

b. SSI only recipients

c. mandatory supplement recipients

d. recipients of State optional supplement payments

Although SSI had established uniform national eligibility criteria and benefit levels for the aged, blind and disabled, it remained true that depending on the State, the maximum amount of cash benefits available to eligible individuals varied because of optional State supplementation.

Prior to 1974, it will be recalled that the rule had been that Medicaid was automatically available to all recipients of cash assistance plus optional groups who could be eligible for cash assistance under Federal regulations but were not actually covered in the State's program for cash assistance. In addition, of course, States could elect to cover the medically needy.

With implementation of SSI, this general rule governing Medicaid eligibility was not automatically carried forward. After 1974, it was no longer strictly true in all States that eligibility for cash assistance automatically entitled an individual to Medicaid benefits. Although a person receiving cash assistance was likely to be eligible for Medicaid, in many States a separate application had to be made. For the most part, both the relationship of Medicaid to cash assistance and the determination of Medicaid eligibility became considerably more complicated, since Medicaid eligibility policy had to accommodate a number of newly created groups of cash assistance recipients. The determination of Medicaid eligibility also became more difficult not only because of the increased complexity of Federal policy but also because of the division of responsibility between the Federal and State Governments in administering cash assistance and Medicaid.

The immediate relationship between Medicaid and cash assistance was altered in view of the increased number of recipients that was expected to occur as a result of SSI. Although the Federal Government was providing fiscal relief to the States by assuming a large portion of cash assistance expenditures, increases in the cash recipient population could substantially increase State expenditures under Medicaid and thus erode considerably the savings to the States resulting from SSI. This effect could be particularly dramatic in those States that had had more restrictive conditions of eligibility for cash assistance and generally were the least able to afford major increases in the State's share of Medicaid expenditures.

In view of the potential impact of SSI on Medicaid expenditures, States were allowed several options for coverage of the new groups of cash assistance recipients created by Title XVI. States, of course, had to continue to make recipients of AFDC eligible for Medicaid. With respect to the aged, blind, and disabled, however, States could choose one of the following

options for mandatory coverage under Medicaid:

a. SSI Option - States could elect to extend Medicaid to all SSI recipients and could, but were not required to, enter into an agreement with the Social Security Administration under Section 1634 of the Act for determinations of Medicaid eligibility. Social Security under this agreement would provide these States with eligibility information for the purpose of issuing Medicaid identification cards and maintaining eligibility files for processing Medicaid claims. This option, to a large extent, preserved the relationship between cash assistance and Medicaid that had existed prior to SSI in all States but offered the State no protection against resulting increases in the Medicaid eligible population. It should be noted, however, that even under a 1634 agreement, States covering the categorically needy only retained residual responsibilities for determining Medicaid eligibility for the aged, blind, and disabled, since a person denied SSI benefits might still be eligible for retroactive coverage under Medicaid (See Part II) or under other optional provisions. In addition, this option also required that States use SSI categorical and financial criteria in making optional medical assistance only and/or medically needy determinations for the aged, blind, and disabled.

It is important to note that a State could elect to extend Medicaid eligibility to recipients of SSI but not enter into a 1634 agreement with Social Security. A few States chose this administrative option, and as a result, SSI recipients in these States

must make a separate application for Medicaid. The major reasons for not entering into a 1634 agreement were to maintain existing State eligibility staff and to maintain unified State administration over all aspects of the Medicaid program.

b. 209-B Option - Section 209-B of PL 92-603 amended the Medicaid law to protect States from increased Medicaid expenditures resulting from SSI. Under this option, States could continue to determine Medicaid eligibility for the aged, blind, and disabled according to the conditions of eligibility and financial standards which were previously used under OAA, AB, and APTD in January, 1972, the year SSI was enacted under PL 92-603. (States could use their January, 1972 criteria or more liberal criteria, if they chose, so long as any new criteria were no more liberal than those used under SSI. States could elect to use more restrictive categorical criteria only, or financial standards only, or both. In addition, they could elect to maintain more restrictive criteria only for certain of the categories, such as the disabled only or the aged only. States could not, however, establish new conditions of eligibility more restrictive than those in effect as of January 1, 1972). As a result, in these States recipients of cash assistance under SSI were not automatically eligible for Medicaid, and the previous relationship between cash assistance and Medicaid was severed. Although many cash assistance recipients in "209-B" States could qualify for Medicaid, they had to make a separate application for Medicaid.

Because more restrictive financial criteria could be used in 209-B States, the determination of Medicaid eligibility against these standards had to be modified for understandable reasons.

Previous recipients of OAA, AB, and APTD, who qualified and received higher payments under SSI, would have lost their Medicaid eligibility in States that elected to maintain more restrictive income standards under the 209-B option. Likewise, in 209-B States using more restrictive income criteria, newly eligible recipients of SSI, who might have qualified for Medicaid on the basis of their income, would be unable to qualify for Medicaid, again for the simple reason that SSI would be supplementing their income above the State's more restrictive standards. As part of the 209-B option, therefore, States electing to use more restrictive standards had to determine Medicaid eligibility after first deducting the amount of an applicant's SSI and/or any optional supplement payment. Thus, in 209-B States using more restrictive income standards, the larger an individual's SSI benefit, the more likely he is to qualify for Medicaid on the basis of income, though he might still be ineligible if the State also imposes resource requirements and categorical criteria more restrictive than those imposed under SSI.

In addition, in 209-B States using more restirctive standards, the amount of an applicant's outstanding medical bills must also be deducted from income in determining Medicaid eligibility for categorically-related individuals. This feature in determining eligibility under the 209-B option is based on the spenddown procedure used under the medically needy option (See Part II), and is variously known as the 209-B or categorically needy spenddown.

Before leaving this complex option it is important to note two aspects of the 209-B option. First, the provisions for deducting the amount of cash assistance and incurred medical expenses are applicable only

for those categories for whom more restrictive criteria are imposed, should the State elect not to impose more restrictive criteria on all categories. For example, if the State imposes more restrictive financial criteria on the aged category only because it is the largest of the categories, blind and disabled individuals would have to be eligible for SSI to qualify for Medicaid and could not establish eligibility under the spenddown. Secondly, although the provisions for deducting the amount of cash assistance and the spenddown are directed primarily at States choosing to impose more restrictive income standards under the 209-B option, these provisions are equally applicable if the State elects to impose any criteria more restrictive than those used under SSI, because of the precise wording of the law. For example, if a State elects to retain a more restrictive definition of blindness but otherwise to use SSI standards for resources and income, individuals who meet this more restrictive definition of blindness must be allowed to spenddown if they have income in excess of the SSI standard.

Apart from the SSI and 209-B options, all States were required to extend Medicaid coverage to certain other special groups created by the implementation of SSI, including:

a. Recipients of mandatory supplements. (Thus, just as the general intent of the law was to protect the cash assistance level of OAA, AB, and APTD recipients who might have been disadvantaged by SSI, likewise their Medicaid eligibility was protected. It is important to note that in 209-B States, mandatory supplement recipients were also to be made exempt from spenddown requirements.)

b. Certain other groups grandfathered for the purpose of Medicaid eligibility only, who did not qualify for a mandatory supplement. (This special grandfathering under Medicaid was necessary to protect certain individuals who were not receiving cash assistance at the time SSI was implemented but who were receiving Medicaid in December of 1973. These special grandfathered groups included individuals in medical institutions and essential spouses covered under OAA, AB and APTD, which were not recognized under SSI.)

Finally, one other type of new cash assistance recipient had to be addressed in Medicaid policy, the recipient of the optional state supplement. It should be recalled that if a State had an optional supplement program, all or only certain categories of aged, blind or disabled recipients could be made eligible to receive an optional supplementary payment. In States electing to cover SSI recipients for Medicaid, SSI recipients who in addition received an optional supplement payment were automatically entitled to Medicaid by virtue of their status as SSI recipients. However, there remained a group of recipients receiving only optional supplement payments because of the level of their income. Coverage of optional supplement only recipients was not made mandatory under Medicaid. And, recipients of an optional supplement could receive Medicaid coverage only if the State's optional supplement program met certain standards. These standards are essentially the standards required for Federal administration of the optional supplement program:

a. Individuals must otherwise be eligible for SSI except for income.

b. The optional supplement must be in the form of a cash benefit, based on need, and regularly paid.

c. It must be made to a reasonable classification of recipients.

These standards were designed to prevent States from making small infrequent payments for the sole purpose of making individuals eligible for Medicaid.

In addition, a Federal limit for the purpose of Medicaid coverage was placed on the extent to which States could supplement the SSI payment. This limit, popularly known as the Medicaid "cap" is 300% of the maximum SSI benefit for an individual. (Currently this limit is $533.40 based on the maximum individual SSI benefit of $177.80, as of July 1, 1977.) States could supplement income beyond this amount, but could not receive Federal funds for Medicaid coverage extended to optional supplement recipients with a gross income above this level. The State established income standards for optional supplementation and optional institutional coverage under Medicaid (See Part II) are also referred to as "caps", though it is important to distinguish between the two uses of the term. It is an important distinction, since gross income is used in determining whether Federal funding will be made available under the Federal Medicaid "cap" whereas eligibility under a State optional supplement or institutional standard is determined on the basis of countable income (income after disregards have been applied.) As a result, some determinations of the Medicaid eligibility of optional supplement recipients may involve both "caps" in cases in which eligibility under a State standard would allow gross income of the applicant to exceed the Federal limit.

IMPACT OF SSI ON MEDICAID ELIGIBILITY

MANDATORY COVERAGE GROUPS - OAA, AB, APTD, AFDC
and/or
OPTIONAL CN COVERAGE GROUPS
and/or
MEDICALLY NEEDY PROGRAM

JANUARY 1974 - SSI IMPLEMENTATION

<u>209-B OPTION</u>

1. AFDC Recipients
2. Mandatory Supplement Recipients Under SSI
3. Aged, Blind, Disabled
4. a. January 72 Criteria
   b. Deduction of SSI and Optional Supplement Benefits
   c. CN Spenddown Requirement
4. Optional CN Coverage Group

CN ONLY

CN/MN

<u>SSI OPTION</u>

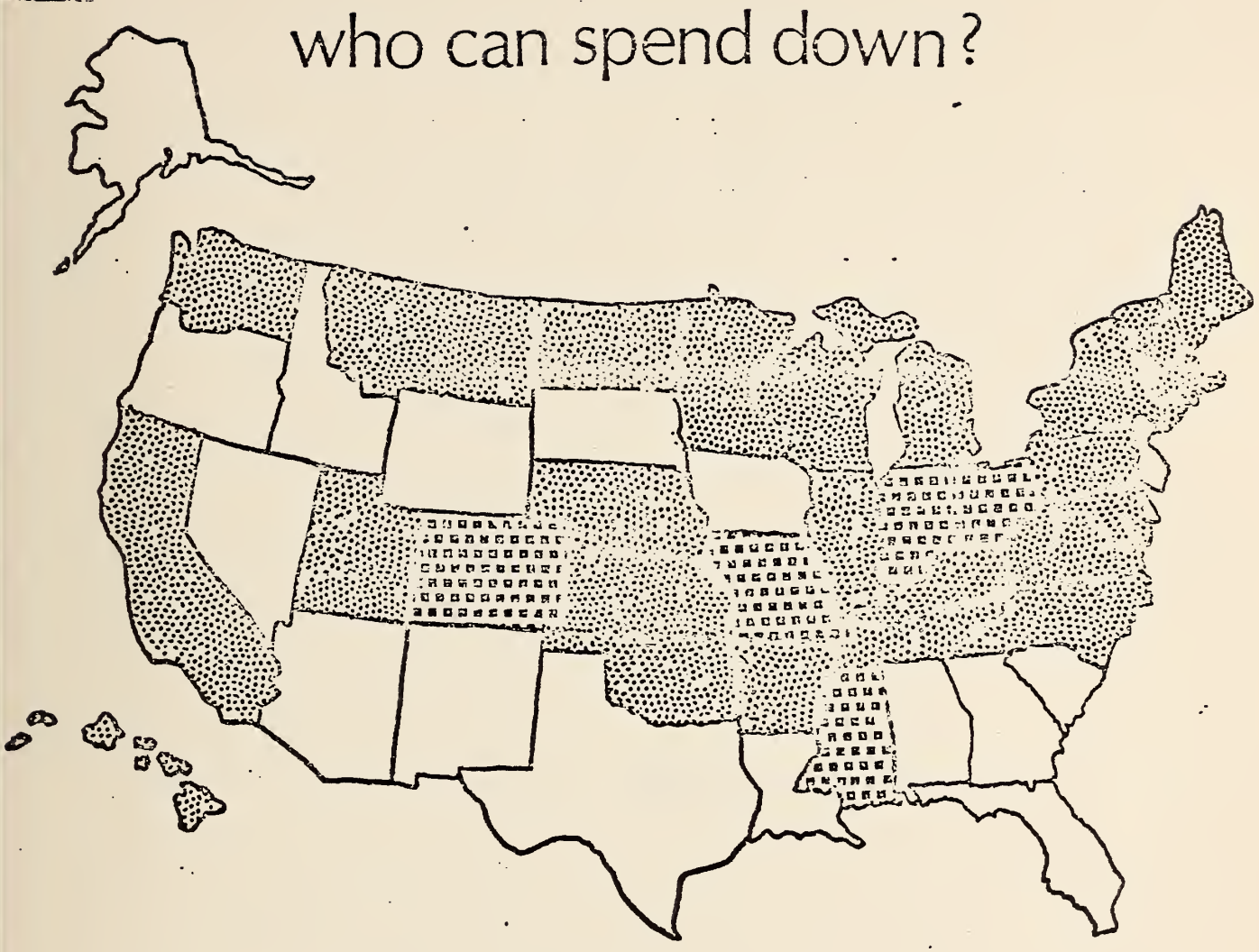
1. AFDC Recipients
2. Mandatory Supplement Recipients Under SSI
3. SSI Recipients
4. Optional CN Coverage Groups

CN ONLY

CN/MN

Chart 1

who can spend down?



medically needy programs
spend-down available to all covered under the State plan

"209(b)" states without medically needy programs
spend-down for aged, blind & disabled only

no spend-down

PART II

RETROACTIVE COVERAGE UNDER MEDICAID

Introduction

Although not a particularly complex provision from the standpoint of policy, the requirement for retroactive coverage is an important feature of the Medicaid program. In order to understand the basis for the retroactive coverage provision it is helpful to examine first the technical distinction between eligibility and entitlement.

People may be eligible for various forms of public assistance, but to receive benefits they must first apply and have their eligibility established or certified. After the eligibility of an applicant has been established, each program of assistance has rules for then determining the beginning effective date for coverage or entitlement under the program. These rules vary among programs. The effective date of entitlement is not necessarily the date on which an applicant first met the conditions of eligibility, and it may or may not be the day on which the application was made. The date or timing of an application is important, however, because it will generally be used to establish the effective date of entitlement.

Entitlement for Cash Assistance

The basic rule under SSI is that coverage begins on the first day of the month in which an eligible individual files a signed and dated application. Thus, an eligible individual who applies for SSI on January 29 will have a date of entitlement, effective January 1. The individual will receive the entire monthly benefit to which he is entitled for the month of January. This procedure is known as full month coverage, that is, if an individual is eligible as of the day of application, he is treated as having been eligible throughout the month in which he applied.

Under the AFDC program (and the previous programs of cash assistance), however, States have several options in establishing the date of entitlement. They may establish the date of entitlement as:

a. the first day of the month in which an eligible family applies, (Full month coverage)

b. the date of application with a provision for pro-rated benefits for partial months of coverage, (Under this option the date of application and entitlement are always the same. Thus, an eligible family that applies on January 20 will receive a partial benefit for January and the full monthly benefit to which they are entitled beginning in February.)

c. or, the date on which the family was certified as eligible or within 30 days of application, whichever period is shorter. (Within this option, States may also elect to establish the date of entitlement on the date of certification or the first day of the month of certification. In either case, under this option not only the day but the month of certification may differ from the day and month of application. Thus, in a State which establishes the date of entitlement on the first day of the month of certification, an eligible family applying on January 15 but whose eligibility is not fully established until February 10 will receive a benefit for February only.)

In general, it should be noted that the cash assistance programs do not make benefits available retroactively except as permitted under the full month coverage procedure. Although an individual or family may have in fact met all the conditions of eligibility for cash assistance for several months prior to application, in no case will a cash benefit be paid for a period in excess of 30 days preceding the date of application.

Basis for Retroactive Coverage Under Medicaid

Unlike the cash assistance programs, three-month retroactive coverage has been required under the Medicaid program since July, 1973, as a result of P.L. 92-603. Prior to that time, retroactive coverage under Medicaid was an optional rather than a mandatory provision. States were required only to cover eligible individuals for purposes of Medicaid eligibility as of the date of application or as of the first day of the month in which the individual or family applied. Since an application for cash assistance also constituted an application for Medicaid, this earlier provision enabled States to use a uniform date of entitlement for both programs, if the State did not elect to provide retroactive coverage under Medicaid and if the date of entitlement under the cash programs was not based on the date of certification.

However, a number of problems were created by permitting States to limit Medicaid entitlement to the date of application.

It should be recalled that unlike cash assistance, which is made available to the recipient in the form of a direct cash payment that can be used for both outstanding obligations and future financial needs, payments for medical services are made to the provider of service and not to the recipient. (Note: The recipient is issued a Medicaid identification card, usually with each cash grant, for use in obtaining services from participating providers who have agreed to bill the Medicaid program for services rendered and to accept reimbursement from the Medicaid program as payment in full.) As a result, an individual must be entitled to Medicaid at the time medical services are received in order for the provider to be reimbursed.

Because of this difference, it was recognized that the timing of an application and the resulting date of entitlement could be a considerably more important factor under Medicaid than under the cash assistance programs because of the high cost of medical care. Likewise, there was growing recognition that people were often unaware of their eligibility for Medicaid and consequently applied for medical assistance only after they had incurred major medical expenses or that they were often unable to apply at the time an unanticipated need for medical care arose. As a result, in States not electing the retroactive coverage option, the very medical expenses that led people to apply for Medicaid could in many instances not be covered under the program because of the rules governing entitlement. For example, a potentially eligible individual who had incurred major hospital and surgical bills the last week in January and who applied for Medicaid upon discharge in February could be entitled only as early as the first of February. Furthermore, in these States, the value of cash assistance could be considerably eroded, if the recipient had outstanding medical expenses that could not be covered under Medicaid.

In order to protect the value of benefits provided under the cash assistance programs in all States and to make the overall provision of medical assistance under Medicaid more effective, retroactive coverage was therefore made mandatory. This requirement became of increased importance when the SSI program was implemented six months later in January, 1974. In States electing the 209-B option, and in States covering SSI recipients but not electing to enter into 1634 agreements with the Social Security Administration, an application for cash assistance no longer constituted a application for Medicaid. As a result, delays could occur in the filing of applications for Medicaid that would affect entitlement. The requirement for retroactive coverage, however, helps to moderate any adverse impact on Medicaid entitlement that could otherwise result from such delays.

Requirements for Retroactive Coverage Under Medicaid

Under the requirement for retroactive coverage, States must extend Medicaid benefits to individuals who have outstanding medical bills that were incurred within the 90-day period preceding the date of application, if the applicant would have been eligible for Medicaid at the time the expenses were incurred. In addition, States may elect to extend full-month coverage under this requirement and therefore make retroactive coverage available up to the first day of the third month preceding the date of application.

It is important to note that retroactive coverage is not automatic. First, although States must inform all applicants of the availability of retroactive coverage at the time of application, not all applicants have outstanding medical bills. For these applicants, entitlement under Medicaid will begin on the date of application or on the first day of the month of application. Secondly, the outstanding medical expenses may be for services not covered under the State's Medicaid program. And, finally, a determination must be made that the applicant was eligible at the time the expenses were incurred.

In this connection, however, an applicant need not be determined eligible at the time of application to qualify for retroactive coverage so long as he was eligible at the time the expenses were incurred. Applications can even be taken on behalf of deceased individuals. Furthermore, an applicant need not have been eligible throughout the entire period to qualify for Medicaid coverage during a portion of the retroactive period. Because of changes in income or other circumstances, a separate determination of eligibility for each month of the retroactive period may be necessary if the applicant has outstanding medical bills in each of these months.

Administration of Retroactive Coverage

After eligibility for retroactive coverage has been established, the applicant will be entitled for each of the months in which the person was eligible and had incurred expenses, and the eligible applicant generally receives a separate Medicaid card for each month of retroactive entitlement, if the applicant was not eligible throughout the retroactive period. To receive coverage during the retroactive period, the eligible individual must request the provider to rebill the Medicaid program. Retroactive coverage is contingent on the provider's willingness to do so, and this may be an important factor in determining whether the recipient actually receives the retroactive medical assistance to which he has been entitled. In this connection, medical bills during the retroactive period which the eligible applicant may have paid or partially paid may also be covered under Medicaid, if the provider agrees to rebill the Medicaid program and reimburse the recipient the full amount he has paid.

It is also important to note that the determination of retroactive eligibility can be affected by the major options for Medicaid coverage of the categorically needy that the State has exercised. In all States, an application for AFDC constitutes in addition an application for Medicaid. As indicated earlier, however, a separate application for Medicaid must be made in 209-B States and States that have elected to cover SSI recipients but have not entered into a 1634 agreement with the Social Security Administration for the determination of Medicaid eligibility. Although delays may occur between the dates of application for cash assistance under SSI and for Medicaid in these States, retroactive eligibility can be determined at the time the individual applies for Medicaid. Any delay, however, will affect entitlement.

In States that have elected to cover SSI recipients as categorically needy and have entered into 1634 agreements, an application for SSI constitutes an application for Medicaid. Thus, a separate application for Medicaid is not required, and the date of application for SSI is the date that must be used in determining retroactive eligibility under Medicaid. Under a 1634 agreement, however, SSI does not make retroactive eligibility determinations but is merely required to determine whether the eligible applicant has outstanding medical bills and to furnish this information to the State. As a result, under a 1634 agreement retroactive Medicaid eligibility is not determined at the time of application, and an eligible SSI recipient with outstanding medical bills generally has to file a separate Medicaid application with the State to receive retroactive coverage. This separate application, however, will be for administrative purposes only and the date will not be used for purposes of retroactive entitlement.

THE MEDICALLY NEEDY PROGRAM

Introduction

The medically needy program is one of the most important overall options for coverage that can be exercised under the Medicaid program.

The general intent of the medically needy option is to permit States to extend the benefits of the Medicaid program to persons who have sufficient income and resources for their support and maintenance (as defined by the rather rigorous standards of financial need recognized under the cash assistance programs) but whose income is not sufficient to meet their medical needs, hence the term medically needy. Although an individual must still be categorically-related, potential coverage under a medically needy program is greatly expanded through the establishment of higher financial standards for determining Medicaid eligibility and the spenddown provision, which permits temporary Medicaid coverage when a person's medical expenses begin to exceed greatly his ability to pay for them. The expanded coverage permitted under a medically needy program affects all categorically-related groups, since States are required to cover as medically needy all categorically-related groups otherwise covered under their Medicaid programs. However, implementation of a medically needy program has perhaps its most dramatic effect on coverage of the elderly. Because of the expanded coverage that may result from this option, it is important to note that States may offer fewer services and a different combination of services to the medically needy than to the categorically needy.

As part of its general goal, the medically needy option is designed to provide continued support for the individual who, as a result of employment, loses eligibility for cash assistance. The structure of the cash assistance programs creates a situation in which even an insignificant increase in income may render an individual or family ineligible for cash assistance and therefore Medicaid in many States. This cut-off point is referred to as the Medicaid "notch", and the loss of Medicaid benefits may more than outweigh the value of any increase in income. The cash value alone of Medicaid benefits can often exceed the value of benefits provided through the financial assistance programs. For example, the cost of only one day in a hospital is comparable to the maximum monthly benefit of $177.80 under SSI.

The loss of Medicaid benefits can be an important factor in personal decision-making about employment or continued employment, particularly if an individual or family has continuing medical needs. In many States the benefits available through Medicaid may include many services such as prescription drugs, eyeglasses, hearing aids, dental care, mental health services, and others, which are often not available under the best of private health insurance plans. And, even under more limited State Medicaid programs, coverage of basic health benefits such as in-patient and out-patient hospital care, physician services, and laboratory and radiological services is more extensive than many people can afford. The medically needy option by permitting continued coverage under Medicaid despite the loss of eligibility for cash assistance serves to eliminate a possible reason for remaining on cash assistance or the necessity of returning to it, should the need for medical care arise.

Eligibility Under a Medically Needy Program

As has been indicated, eligibility for Medicaid under a medically needy program may be established in two ways.

First, higher medically needy income levels (MNILs) may be established for the purpose of determining Medicaid eligibility which create income eligibility zones above the financial standards of eligibility for cash assistance, as illustrated in Chart 3. The medically needy income levels are computed on the basis of the maximum cash payment permitted under a State's AFDC program, and they must vary by family size. For purposes of Federal funding, however, the medically needy income levels may not exceed 133% of the maximum AFDC benefit by family size. Categorically-related individuals or families with countable income below the appropriate MNIL are eligible for coverage under Medicaid on the same basis as recipients of cash assistance and are termed the non-spenddown medically needy. (Note: Countable income is determined in accordance with the procedures of the cash assistance program to which the applicant is categorically-related.) Like recipients of cash assistance in non-209-B States, the non-spenddown medically needy are made eligible for Medicaid benefits for a fixed prospective period, and their income and resources are periodically reevaluated. If there is no change in the individual's circumstances, the non-spenddown medically needy eligible will remain continuously eligible for Medicaid.

Secondly, categorically-related individuals who cannot qualify as non-spenddown medically needy because of their income must be permitted the opportunity to establish eligibility for Medicaid through the spenddown

MN - Same coverage groups as CN

Mandatory services or
any seven services plus
any or all other services
provided categorically needy

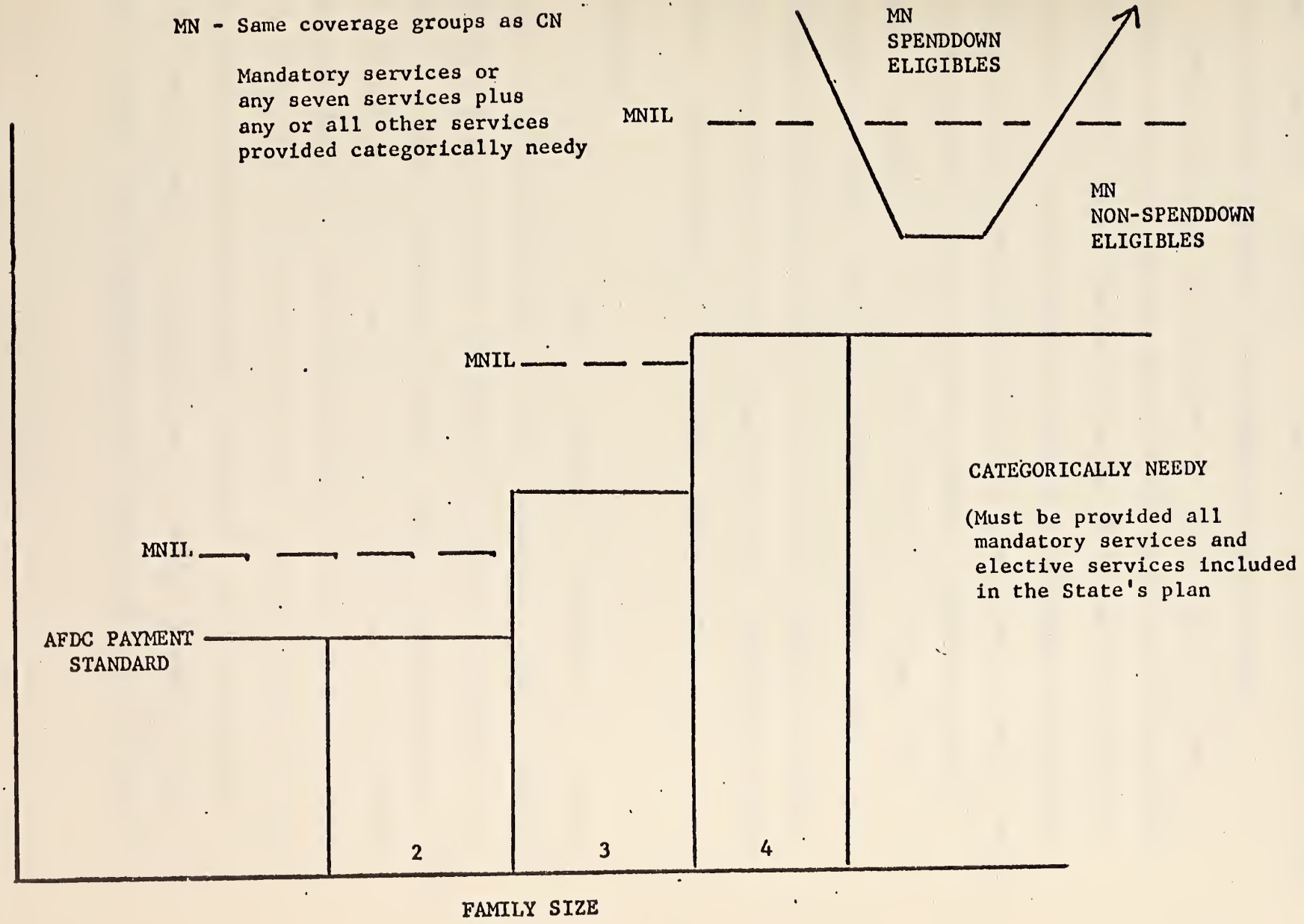


Chart 3

Chart 3

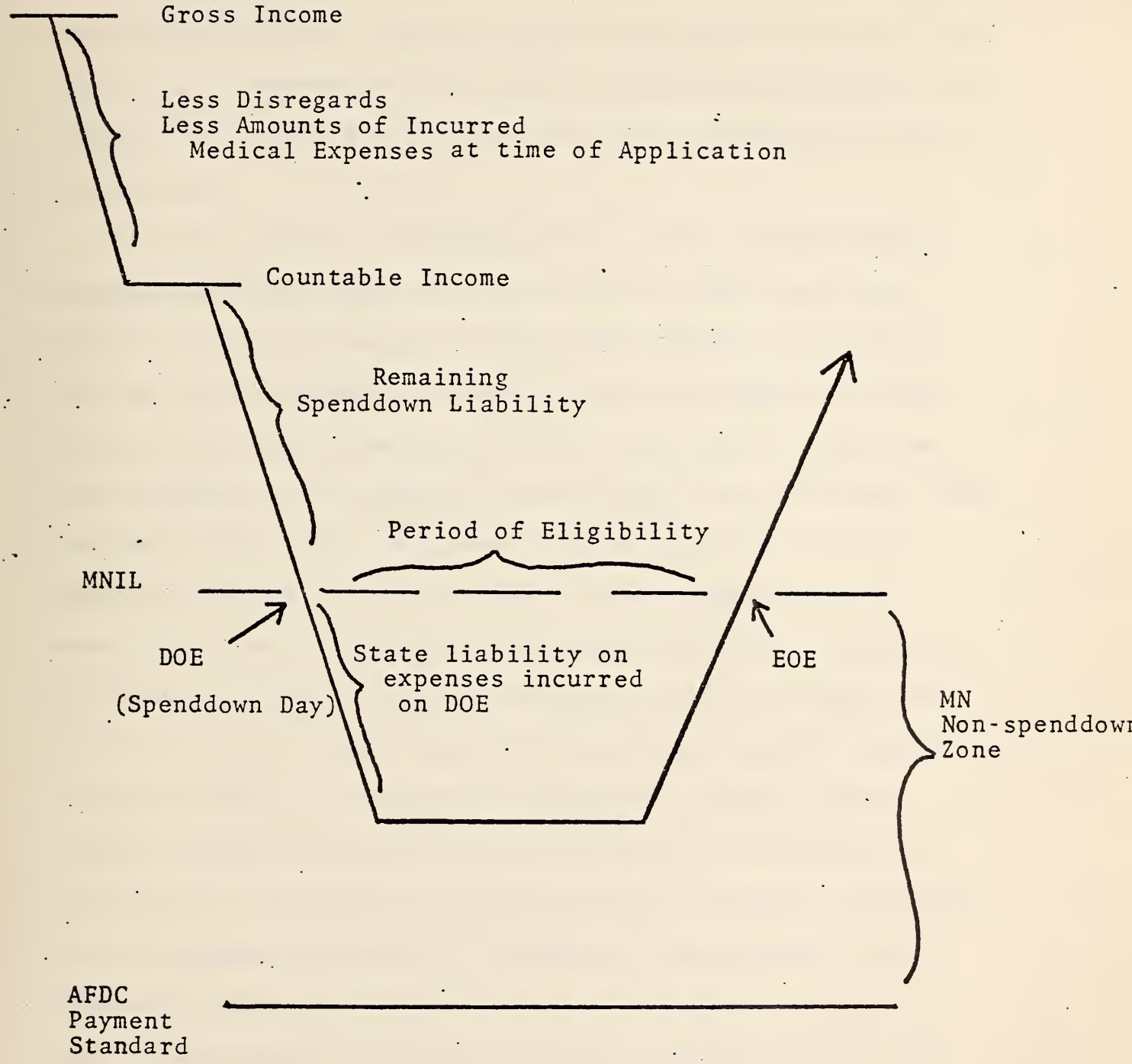
procedure, that is, by having their incurred medical expenses deducted from countable income in determining financial eligibility against the appropriate, family-sized MNIL. Individuals or families who establish Medicaid eligibility in this manner are referred to as spenddown medically needy.

Before discussing the spenddown procedure in greater detail, an important distinction between the non-spenddown and spenddown medically needy should be noted. Whereas the non-spenddown medically needy are presumed to be in need of medical assistance, individuals with income above the medically needy level must actually be in need of medical assistance, as measured by incurred medical expenses. Because eligibility under the spenddown is based on incurred expenses, coverage under the spenddown provision is primarily retroactive in nature. Unlike a non-spenddown determination in which a person becomes eligible for Medicaid for a fixed prospective period, eligibility under a spenddown determination may often terminate as of the day of application.

Spenddown

As briefly noted in Part I, individuals or families with income in excess of the applicable medically needy income level incur a spenddown liability, which represents the difference between the individual's or family's countable income and the MNIL. Bills for incurred medical expenses are then deducted from, or applied against, the amount of the computed spenddown liability in establishing eligibility for Medicaid. Coverage will begin on, or extend back to, the date on which a medical bill was incurred that reduced income below the medically needy income level, as illustrated in Chart 4. Generally one in a series of medical bills will reduce income below the medically needy income level, and for this bill,

SPENDDOWN



KEY:

DOE - Date of Entitlement
EOE - End of Entitlement

Chart 4

known as a split claim, both the applicant and the State will be partially responsible for payment. Medicaid will then pay for any additional claims incurred on the spenddown day not counted in establishing eligibility, and eligibility will extend from the spenddown day to the end of the period of consideration.

It can be seen that the medically needy income level represents a protected maintenance level, that is, an amount of income considered essential for an individual's or family's basic support and maintenance. Under the spenddown provision, Medicaid coverage is intended to be made available at that point when an individual or family can no longer meet medical expenses out of available income and still provide for his or their other basic needs. Thus, the spenddown provision serves as a form of catastrophic coverage, with the spenddown liability representing the extent of applicant's ability to pay for medical care costs. Eligibility and the amount of medical assistance available under the spenddown will therefore vary in accordance both with the applicant's need for medical care and his ability to pay for it. Although the spenddown liability represents medical expenses for which the applicant is responsible for payment and for which income has been budgeted in determining eligibility under the spenddown, eligibility for Medicaid is not contigent on the applicant's actual payment of these expenses. An applicant need only incur sufficient medical expenses to offset his spenddown liability in order to establish Medicaid eligibility.

Two other aspects of the spenddown provision should also be noted. First, in computing initial spenddown liability, Federal regulations require that incurred medical expenses be considered in a certain order based on whether the expenses are services covered under the State's Medicaid program. Income is to be reduced first by incurred medical

expenses which are not covered by the program, including expenses incurred for private health insurance and Medicare premiums. This procedure is designed to help insure that, should the spenddown applicant have medical expenses greater than needed to establish eligibility at the time of application, the remaining medical expenses can be covered by the Medicaid program. However, should the applicant not establish immediate eligibility but have a remaining spenddown liability to be offset by future medical expenses, further incurred expenses may be considered by date order, whether or not they are covered under the State's Medicaid program.

Secondly, any incurred medical expenses may be used in establishing eligibility under the spenddown so long as it is a valid bill for which the individual is still liable for payment, whenever it was incurred. However, under the requirements for retroactive coverage under Medicaid, a State Medicaid program cannot pay for any medical claim incurred more than three months in advance of the date of application and receive Federal matching funds (or prior to the first day of the third month preceding application. See Retroactive Coverage). In this connection, bills which the applicant may have paid can be counted as incurred expenses in determining eligibility, if they were bills for service within the three month retroactive period.

Period of Consideration and Entitlement Under the Spenddown

Establishing Medicaid eligibility under the spenddown provision occurs over time. Income is evaluated, and the amount of spenddown liability is computed on the basis of fixed time periods, which may be shorter but not longer than six months. Eligibility under the spenddown must be achieved within this fixed period. Depending on the level of an individual's income and the size, number or frequency of his medical expenses, eligibility may be achieved quickly or slowly or not at all. At the end of this period, an individual loses his entitlement to Medicaid and incurs a new spenddown liability, which must be offset by new medical expenses before eligibility for Medicaid can be reestablished. Thus, eligibility for the program under the spenddown is not continuous, as illustrated in Chart 5.

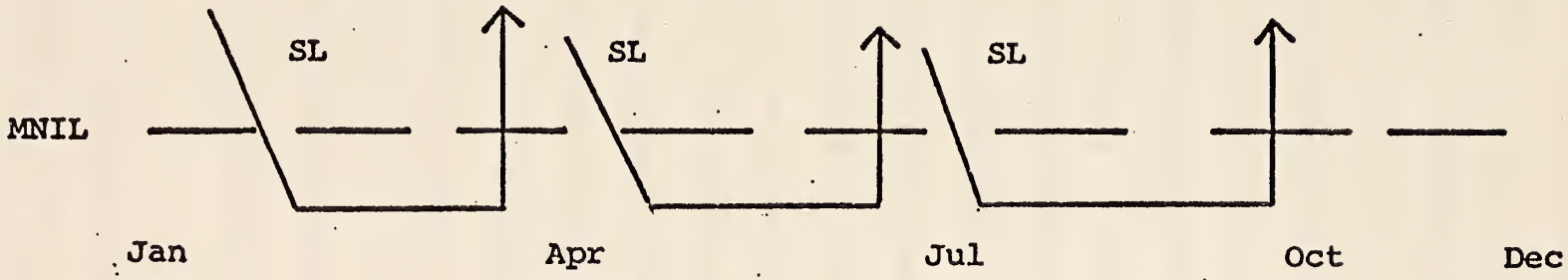
As an example, assume a State uses a fixed quarterly period of consideration. A categorically-related individual with no incurred medical expenses applies for Medicaid and is determined to have a spenddown liability of $150. This individual must incur medical expenses in excess of $150 to establish eligibility, and these expenses must be incurred within the quarter of consideration. If he applies on January 1 but does not incur medical expenses sufficient to meet his spenddown liability until February 1, his period of eligibility will be only two months, i.e., February and March. At the end of March his entitlement under Medicaid ceases, and he must reapply for Medicaid if he continues to have medical expenses for which he needs assistance in paying.

In the example above, the determination of eligibility was for a prospective period only, since the hypothetical applicant had no incurred medical expenses. However, generally people turn to Medicaid for assistance

Chart 5

DISCONTINUOUS COVERAGE UNDER SPENDDOWN

(Quarterly Period of Consideration)



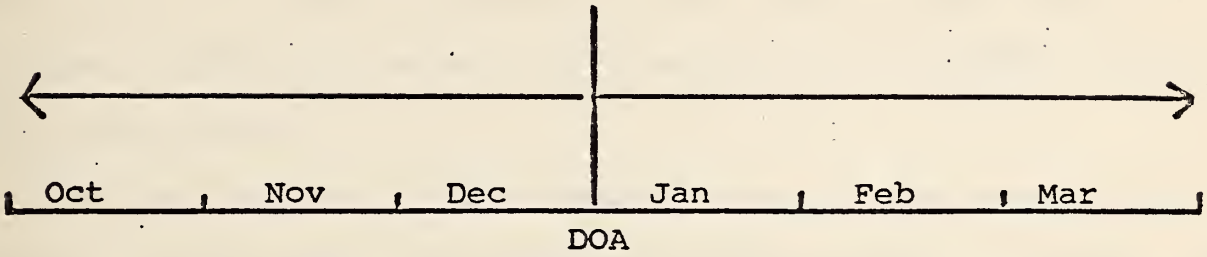
only after medical expenses have been incurred which they are unable to pay or for which they need some assistance in paying, and spenddown determinations are usually of chief importance in covering expenses prior to the date of application for Medicaid. Using a quarterly period of consideration, for example, an applicant may have had medical expenses in the quarter preceding the date of application which would have met his spenddown liability, had he applied earlier. Assume an individual applies on January 1, with sufficient outstanding medical expenses to meet his spenddown liability by November 1. The individual would be retroactively eligible for Medicaid from November 1 up to the date of his application. The individual would then request the hospital or physician to rebill the Medicaid program for those bills incurred after the spenddown day of November 1. As of the date of application in this example, it is important to note that a new quarter of consideration begins. Thus, on the date of application in this example, the individual has a new spenddown liability which must be offset by further medical expenses before eligibility and coverage under Medicaid will continue or more correctly resume. Even though there may have been no changes in the individual's income, his spenddown liability will be greater than it was during the retroactive period, since his previously incurred medical expenses have either been paid by the Medicaid program or taken into consideration in determining his eligibility during the retroactive period.

Because of the discontinuity in coverage under the spenddown and the requirement for retroactive coverage under Medicaid, two basic approaches have evolved in determining initial Medicaid eligibility through the spenddown process.

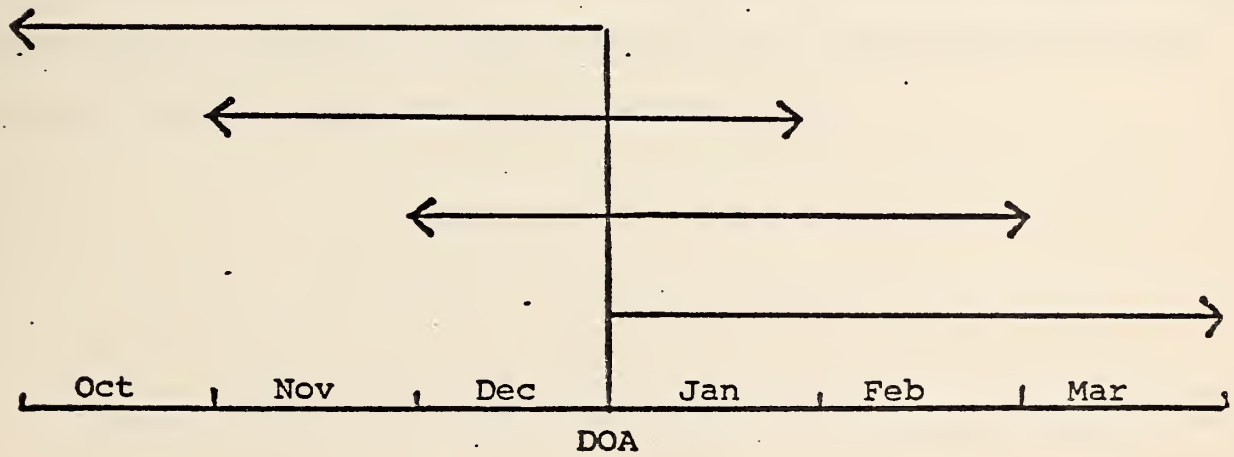
The first approach is the use of the fixed period of consideration. Under this approach, eligibility is always first determined from the date of application for the entire retroactive period, if the individual had incurred medical expenses during this period. If a quarterly period is used, a determination of eligibility including recomputation of spenddown liability is then made for the prospective period of consideration beginning from the date of application. Using a quarterly period under this approach, the date of application always marks the end of one period of consideration and the beginning of a new one, and a break in Medicaid coverage will always occur between these periods because of the spenddown in the prospective period. If a semi-annual period is used, there is no break in coverage, since the three month retroactive period is included in the total six-month period of consideration.

The second approach is somewhat more flexible and incorporates the use of a floating period of consideration. Under this approach, the period of consideration is the same for all applicants (that is, the period covers the same length of time, a quarter or semi-annual period), but the beginning date of the period can be set at any point in time up to a full three months prior to the date of application, depending on the needs of the individual applicant. For example, if no medical expenses were incurred three months prior to the date of application but were two months before, the period of consideration can be set at the beginning of the second month, as illustrated by Chart 6. Under this approach an individual may be eligible retroactively and for a period extending past the date of application, whether or not a quarterly or semi-annual period of consideration is used.

FIXED PERIOD OF CONSIDERATION
(Quarterly)



FLOATING PERIOD OF CONSIDERATION
(Quarterly)



KEY: DOA - Date of Application

Chart 6

Whatever approach a State adopts, it is important to note that the length of the period of consideration can affect eligibility. Generally, the shorter the period of consideration, the easier it is to establish eligibility, since less total income is taken into account. Shorter periods, thus, result in smaller spenddown liabilities. The period of consideration, may be as short as a month. The monthly period, while the most liberal, is burdensome to administer, and as a result most States have adopted a quarterly or semi-annual period.

The effectiveness of a State's medically needy program in serving the worthwhile goals for which the program was designed can vary. In States, with low AFDC payment standards, coverage of the non-spenddown medically needy may be quite restrictive by virture of the narrow non-spenddown eligibility zones that are created. In addition, low medically needy income levels increase the amount of spenddown liability that spenddown applicants must meet in order to establish eligibility. As a result, even a person who does establish eligibility under the spenddown provision may still have large medical expenses for which assistance under Medicaid is not available.

Medically Needy and 209-B Options

Prior to implementation of SSI in January, 1974, the spenddown procedure was a unique feature of the medically needy option. However, upon implementation of SSI, it will be recalled that States which elected not to cover all SSI recipients under Medicaid as categorically needy were required to use the spenddown procedure in establishing Medicaid eligibility for the aged, the blind, and disabled, if criteria more restrictive than those of SSI were imposed.

It is important to note that the 209-B option pertains to mandatory coverage under Medicaid. A State, as a result, may exercise both the 209-B and the medically needy options, and in fact a number of States that covered the medically needy prior to 1974 did so. Because medically needy States were providing expanded coverage under Medicaid prior to SSI, limiting the impact of SSI on the size of the Medicaid eligible population was not necessarily the major consideration for exercising the 209-B option in States covering the medically needy.

Rather, by electing the 209-B option, medically needy States could avoid the need for extensive retraining of Medicaid eligibility staff in SSI policy and the need for close coordination with the Social Security Administration (unlike medically needy States exercising the SSI option), and eligibility could continue to be determined in much the same manner and against the same criteria as it had been prior to implementation of SSI. Since the spenddown was already a feature of the medically needy program, new procedures did not have to be developed to meet this requirement under the 209-B option. Aged, blind, and disabled individuals could

establish eligibility by spending down to the medically needy levels as before.

In medically needy 209-B States, the distinction between categorically and medically needy individuals is preserved. In non-medically needy 209-B States, categorically-related individuals, where applicable, spenddown to the same income level whether they are cash assistance recipients or not. In medically needy 209-B States, the amount of cash assistance benefits is still to be deducted from income in establishing eligibility for those categories in which more restrictive criteria are imposed. SSI recipients and optional supplement recipients who qualify after the deduction of cash benefits or through the spenddown against the more restirctive income standard are treated as categorically needy. However, aged, blind, and disabled individuals who are not recipients of cash assistance are treated only as medically needy, and their eligibility is determined only against the medically needy income level. This distinction can be important, if the State provides fewer or different services to the medically needy than to the categorically needy.

COVERAGE OF INDIVIDUALS IN MEDICAL INSTITUTIONS UNDER MEDICAID

Introduction

The institutional services for which special eligibility provisions have been established under Medicaid are extended or long term care services, and the term medical institution in this context applies primarily, though not exclusively, to nursing homes. Under Medicaid, all States must provide skilled nursing facility (SNF) services and may elect to provide intermediate care facility (ICF) services for the categorically needy. In addition, States may elect to include either or both these services for the medically needy but are not required to do so. Nursing homes have to meet a number of standards to qualify for participation under the Medicaid program as skilled or intermediate care facilities. This can be an important consideration. An individual in a nursing home may be eligible for Medicaid, but unless the facility meets the standards for participation, the Medicaid program cannot cover the cost of the services provided by the institution. Likewise, apart from other conditions of eligibility, an individual must be determined to be in need of skilled or intermediate care before the cost of his care can be met by the Medicaid program.

These institutional services under Medicaid and the provisions for determining eligibility for institutionalized individuals merit special consideration for two reasons. First, from the standpoint of policy, Medicaid eligibility determinations for institutionalized individuals are unique in some respects and the options for institutional coverage

somewhat confusing. Secondly, from an overall program standpoint, the institutional coverage available under Medicaid is perhaps the single most socially significant feature of the entire program. It is significant both because of the growing demand for long term care and because of the high, and ever increasing, cost of providing it.

The need and demand for this type of care has grown dramatically within recent years as a result of changes in the family structure, of the increased mobility of American life, and of increased life expectancy.

Medicaid is the only major program, public or private, that provides long term care benefits (with the exception of limited benefits available under Medicare and through the Veteran's Administration). As a result, the Medicaid program has come to play a predominant role in the provision of long term care services. According to a recent staff report to the House Committee on Interstate and Foreign Commerce, Medicaid expenditures for nursing home services alone account for 48.7 percent, or almost half, of all expenditures for this type of care, including private as well as other public sources. (Medicare and VA, by way of contrast, account for less than 5 percent with the private sector accounting for 47 percent). Long term care expenditures are the single largest item in the Medicaid budget. They account for almost 40 percent of all Medicaid expenditures on a national basis and in many States account for well over 50 percent of their total program expenditures. These rather dramatic statistics reflect the fact that a determination of Medicaid eligibility for an institutionalized individual can result in a substantial commitment of

public funds ranging anywhere from approximately $350 to over $700 a month (depending on the level of care provided by the facility) for a period which may extend from a few months to several years.

It should also be noted that the aged are not the only beneficiaries of the institutional coverage provisions under Medicaid. One of the intermediate care services that can be included under a State's Medicaid program is care in specialized medical institutions serving the mentally retarded (ICF/MRs), many of which furnish care primarily to children and young adults. Since implementation of SSI, the Medicaid program in many States has assumed an expanded role in paying for the cost of this type of care for two reasons. First, unlike the previous program of APTD, SSI does not recognize an age limit in determining disability. And, secondly, SSI does not consider parental income in determining the eligibility of an individual under 21 after his first full month in a medical institution. As a result, virtually any child who is sufficiently retarded to require institutional care on a full-time basis and who has no other source of income can qualify for SSI and therefore Medicaid in many States.

Impact of Institutionalization of the Receipt of Cash Assistance

Before discussing the options for institutional coverage under Medicaid, it is important to consider first the impact of institutionalization on eligibility for cash assistance. Since this would require a highly technical discussion of the provisions of specific State plans for AFDC and various provisions under SSI, only a few general observations will be made.

The current cash assistance programs are not basically designed to cover the cost of needed medical care but rather to provide financial assistance to an eligible individual in an independent living situation. As a result, an individual who enters a medical institution for more than a temporary period will generally lose his eligibility for cash assistance, unless he has little or no income of his own. Eligibility for cash assistance is generally terminated on the assumption that the cost of care in the institution will be covered by the Medicaid program or some other source and thus the individual's needs for support and maintenance are being met during his stay in the institution. (Note: If Medicaid is not expected to cover the cost of care, SSI will not generally reduce or terminate benefits. This situation can occur, for example, if the individual is in a nursing home not meeting the conditions for participation in Medicaid or in a home providing only intermediate care in a State which has elected not to cover this service under Medicaid. However, as a practical matter, even the full SSI benefit is generally not sufficient to meet the cost of institutional care for an individual in this situation without additional support from another source, including the individual's relatives, community, or in some cases the institution itself).

SSI and a number of AFDC programs do, however, provide limited cash assistance to eligible individuals in medical institutions who have insufficient income to meet even personal care needs while in the institution. A reduced financial standard is used for determining the initial eligibility of an institutionalized individual and for redetermining the eligibility of a current cash assistance recipient who has entered and is

expected to remain in a long term care institution for an extended period. This reduced standard under SSI is currently $25 for a single individual, and it represents the maximum payment that can be made to an SSI recipient in a medical institution after the month of entry. Thus, in general an institutionalized applicant for, or recipient of SSI must have countable income (after disregards) of less than $25 to be made eligible or to remain eligible for a cash benefit. SSI recipients with countable income in excess of this amount will generally lose their eligibility after the month of entry and for as long as they remain in the medical institution, since they have sufficient income of their own to meet their personal needs in the institution.

Options for Coverage of Institutionalized Individuals Under Medicaid

The basis for establishing the Medicaid eligibility of individuals in long term care institutions varies considerably from State to State, depending on the major options for coverage of the categorically needy the State has elected and depending on whether or not the State has exercised the medically needy option.

The primary option under Medicaid for coverage of individuals in medical institutions is for coverage of individuals who would be eligible for cash assistance except for their institutional status. This is a technical option designed to overcome the provisions under the cash assistance programs for a reduced standard in determining the financial eligibility of institutionalized individuals, as previously discussed. Without this option, cash assistance recipients would in most cases lose their eligibility for financial assistance and therefore Medicaid at the time it was needed most, that is, when they entered a long term care

institution. Depending on the State, however, this option may or may not be relevant. (Note: Because the majority of institutionalized individuals are primarily the aged, blind, and disabled and because of the variations in State plans for AFDC, the following discussion will exclude consideration of AFDC recipients who become institutionalized).

This basic institutional coverage option under Medicaid is of little relevance in determining institutional eligibility in States that cover the categorically needy only under the 209-B option (except for coverage of institutionalized AFDC recipients, for which the option remains important) or in States that have medically needy programs covering skilled and intermediate care facility services. In these States Medicaid eligibility is not solely contingent on eligibility for the receipt of cash assistance because of the spenddown, and no special options are therefore required in these States to extend Medicaid to individuals in long term care institutions.

This basic institutional coverage option, however, is important in States (1) that limit Medicaid coverage of the aged, blind and disabled to SSI and/or optional supplement recipients, or (2) that cover SSI recipients and/or optional supplement recipients plus the medically needy but which do not provide SNF or ICF services under their medically needy programs. In these States, the Medicaid eligibility of institutionalized individuals is contingent on eligibility for cash assistance. Thus, this basic institutional option protects the Medicaid eligibility of cash recipients in these States who become institutionalized so long as they remain eligible for cash assistance outside the institution. Similarly, under this option individuals in a medical institution can apply for

Medicaid and have their eligibility determined against the general financial standards for cash assistance, or outside standards, rather than the reduced standards actually used in determining eligibility for cash assistance in those cases. The outside standard will be the standard payment amount under SSI ($177.80 currently), or the applicable optional supplement standard, if the State has a program of optional supplementation and if it extends Medicaid coverage to recipients of optional supplementary payments.

The fact that eligibility for Medicaid for institutionalized individuals remains tied to an outside standard under this option means that modest increases in income may result in ineligibility for Medicaid (as opposed to a change in spenddown liability in 209-B or medically needy States.) The effect of this notch, or cut-off point, on the institutionalized patient is particularly traumatic, since it leaves the patient unable to pay for care in the institution and presents the institution with the dilemma of releasing the patient or subsidizing his care, if other sources of funding cannot be located.

There is one other institutional coverage option. It is of basic importance, again, in categorically needy only States which limit Medicaid coverage to SSI recipients, SSI States which either do not have a program of optional supplementation or limit optional supplementary payments to reasonable classifications, and medically needy States which do not cover SNF or ICF services for the medically needy. This additional option permits States to extend Medicaid coverage to all aged, blind, and disabled individuals in medical institutions who have income within the Federal Medicaid cap, even though the State may not in fact have a program of optional supplementation. In other words, under this option

States may determine eligibility for institutionalized aged, blind, or disabled individuals against a higher income standard, whether or not it constitutes a genuine outside standard. This higher institutional standard may be set lower than the Federal Medicaid cap at the option of the State.

It should be noted that in States which limit Medicaid coverage of the aged, blind, and disabled to recipients of SSI, this additional institutional cover option enables individuals to qualify for Medicaid primarily on the basis of their need for care in a medical institution, since many individuals who qualify for Medicaid under this provision would not in fact be financially eligible for cash assistance outside an institution. This option evolved from previous practices under the earlier cash assistance programs. States without medically needy programs had sometimes used hypothetical special needs standards as a means of extending Medicaid eligibility to institutionalized individuals. These special standards were generally based on the estimated amount of financial assistance that would be needed by an individual to pay for care equivalent to that provided in an institution, though cash payments based on these special standards were seldom, if ever, made to individuals not in an institution.

Determining Medicaid Eligibility for Institutionalized Individuals

The procedures for determining eligibility for institutionalized individuals will vary according to the State and the coverage provision under which eligibility is established, e.g., whether eligibility is established through a spenddown or against an outside standard. In determining categorical eligibility and the amount of countable income

available to an individual for the purpose of Medicaid eligibility, the methods and criteria of the cash program to which the individual is categorically related will apply. The resource standards of the cash program to which the individual is categorically related will also apply with the exception of medically needy determinations, in which the medically needy resource standards will be used. These rules are applicable to all States whether they have elected to use SSI criteria or have elected the 209-B option, although in 209-B States the methods and criteria of the previous cash assistance programs will generally be used.

A discussion of the specific rules concerning the availability and treatment of income (including that of a spouse) to be used in determining eligibility for institutionalized individuals is beyond the scope of this section. It is sufficient to note that in determining financial eligibility under the cash assistance programs, certain amounts of income are generally disregarded to establish countable income, which is then applied against a financial standard. If countable income is less than the financial standard, financial eligibility is established and the difference between countable income and the financial standard will generally represent the amount of the cash benefit to be paid. This same basic procedure is used in establishing Medicaid eligibility for institutionalized individuals against an outside standard or through a spenddown provision, that is, countable income is used in determining income eligibility against the outside standard or against a medically needy income level.

Application of Income to the Cost of Care

After eligibility has been established, however, a separate and further determination is then made in all institutional cases to deter-

mine the amount of income of the individual that may be applied toward the cost of his care in the institution. Because of the reduced need of an institutionalized individual for income to meet his needs while in the institution and because of the high cost of institutional care, Federal regulations require that an individual's income be used to reduce the Medicaid payment made to the institution on his behalf. For example, in some States the institutional standard for determining eligibility is set as high as Federal Medicaid cap (that is, at 300 percent of the maximum SSI benefit for a single individual, currently $177.80), which creates an institutional standard of $533.40. Thus, an institutionalized individual with income of $500 a month easily qualifies for Medicaid benefits. Since the individual's needs for food, shelter, and medical attention are being met, much of his income is to be considered available to offset the cost of his care. Accordingly, Medicaid will pay the difference between the individual's available income and the cost of care in the institution.

In determining the amount of income available for application to the cost of care, the procedures used in determining eligibility do not apply. For example, income disregarded in establishing eligibility is counted in determining the individual's liability toward the cost of his care. It should be emphasized that the process of applying income to the cost of care is done in all cases in all States, no matter how eligibility was established.

However, in determining the amount of income that may be used to reduce the payment to the institution, certain amounts must be protected for the individual's personal needs in the institution and for the needs of a spouse and any dependents in the individual's home. Under Federal

regulations a minimum of $25 must be protected for personal needs, though States may establish a higher protected personal needs amount. The minimum level of income that must be protected for the maintenance of a spouse or dependents outside the institution is not specified in Federal regulations. (States are permitted some flexibility in establishing these protected levels though the amounts established must be reasonable.) Federal guidelines, in addition, require that income of an individual be protected to meet medical expenses that are not covered under the State's Medicaid program. However, the extent to which States have implemented this latter requirement varies, primarily because of the complexity of its administration. It should be noted that these protected levels are amounts of an individual's own income that are to be excluded in determining available income to be applied to the cost of institutional care. They do not represent payments.

The application of income to the cost of care is similar in some respects to the spenddown procedure in that the individual has a liability for a portion of his medical care costs, and the term spenddown is sometimes loosely used to denote this feature of institutional determinations. It is important to distinguish between the two procedures, however, for the sake of clarity. Spenddown is a procedure used to establish eligibility for Medicaid. The application of income to the cost of care is a separate procedure used only after eligibility has been established and only used in institutional cases. Both procedures will generally be used in determining eligibility and the patient's liability for the cost of institutional care in medically needy and 209-B States.

PASS ALONG PROVISIONS

One of the major sources of income (and often the only other source of income) for many recipients of cash assistance is Social Security benefits under Title II. Annual cost of living increases in Social Security benefits frequently render many cash assistance recipients ineligible for further cash benefits and perhaps more importantly for continued coverage under Medicaid. This happens despite the fact that cost of living adjustments are also made annually in SSI benefits.

As a result, recent legislation has been enacted to protect the Medicaid eligibility of SSI recipients who lose their eligibility for SSI and Medicaid solely because of Title II cost of living increases. Under this provision of the law, commonly known as a pass along provision, States must disregard the cost of living increase under Social Security which rendered an SSI recipient ineligible and future cost of living increases in determining continued eligibility for Medicaid. In other words, if a person was receiving SSI and would continue to be eligible for SSI and Medicaid except for cost of living increases under Social Security, then the person will remain eligible for Medicaid, if there are no other changes in his circumstances. This pass along provision was made effective for all cost of living increases after April, 1977, and it is applicable in all States, whether they cover all SSI recipients under Medicaid or have exercised the 209-B option. (It is equally applicable in 209-B States, since SSI benefits are deducted from income in establishing Medicaid eligibility where criteria more restrictive than those under SSI are imposed.)

It is important to note that not all Medicaid recipients who receive Social Security benefits are protected under this pass along provision. The individual must have been receiving both SSI and Social Security benefits to qualify for continued Medicaid coverage under this provision. Thus, the major groups of Medicaid recipients, who are currently not protected are recipients of State optional supplement payments only and many individuals in medical institutions who are not actually receiving the reduced institutional benefits under SSI (even though they might be eligible to receive SSI outside the institution).

(NOTE: There was an earlier, one-time pass along provision that protected the Medicaid eligibility of individuals who lost their eligibility for cash assistance as a result of a 20 percent increase in Social Security benefits that occurred in 1972. It also applied to individuals who would have been eligible for cash assistance except for this increase ad to institutionalized individuals, unlike the current pass along provision. Individuals who remain eligible for Medicaid under this earlier pass along provision are a grandfathered Medicaid coverage group.)